Obstetric Drills

Content

Multidisciplinary drills taking place in a clinical area during 3 hour session to include training in:
- Maternal collapse
- Recognising the deteriorating/unwell woman
- Eclampsia
- Obstetric haemorrhage: APH & PPH

Attendees
- Hospital based midwives
- Community midwives
- Junior medical staff
- Senior obstetricians
- Healthcare assistants and maternity support workers
- Operating department practitioners working on the delivery suite
- Junior anaesthetists during their rotation through the department
- Senior anaesthetists

Trainers
It is expected there would be a minimum of 1 trainer to 6 trainees

Objectives
- Recognise the importance of good team working in emergencies
- Understand the elements of good communication
- To understand own role in emergency situation
- Be able to instigate emergency care including summoning help
- To appreciate the value of contemporary documentation
- Be able to provide supportive care to women and their birth attendants in emergency situations
- To assess the effectiveness of their actions
- To recognise aspects for self improvement/ development
- To Identify and address any learning issues for the individual, the group, the organisation or for the trainers

Overview
During the session there will be 3 clinical scenarios:
- Severe hypertension
- Obstetric haemorrhage
-Either maternal collapse OR the deteriorating patient

The choice of the third case will depend on the skill mix amongst the trainees and the trainers
One of the scenarios will be a community based scenario
Maternal Collapse

Aims

- To demonstrate the ability to initiate emergency measures in response to a maternal emergency
- To demonstrate team-working skills
- To demonstrate good communication skills

i) Hospital setting (video)
Scenario: previous LSCS in labour at 5cm, epidural sited and top up given - feels unwell, pale, decreased response to verbal stimulus

Participants: MW1, MW2, co-ordinator, HCA, obstetricians x2, anaesthetist x1, ODP, role player
Video feedback highlighting good (and bad) examples of communication and good team working). Ask all participants what they felt their role to be in scenario

ii) Community setting (no video)
P3, normal delivery, day 1 visit by CMW, c/o chest pain through night. Collapses when asked to move onto bed to check uterus

Participants: role players for patient and mother/sister, CMW

Use active observer sheets as small number of participants (appendix 1)
Deteriorating patient - structured discussion, no video

Aims
- To understand the correct use of the MOEWs chart
- To understand the actions required when the MOEWs score is increased
- To appreciate the potential seriousness of sepsis in obstetric patients

i) Hospital setting
P2, 2/7 following SVD at term, pyrexia of 37.2-37.5°C since delivery, dry cough, on amoxicillin.

MW1 just taken over care (from facilitator), reviews MOEWs chart, 2 yellows
Calls first responder, meantime starts corrective measures
After 30 mins, no doctor arrived, repeats obs worse
Calls 2nd responder and requests co-ordinator

ii) Community setting
Day 5 post LSCS. Routine visit but woman states she feels unwell. Looks flushed & agitated. Discuss actions

Performs set of obs and document on MOEWs chart (pulse 112bpm and RR 26/min, temp 35.9°C)

Recognises need for medical review and phones for help (if phones GP, not able to attend). Discuss possible corrective measures & frequency of obs

Requests admission to DS - meanwhile obs worse

On admission - reviewed by obstetrician, MOEWS x2 red
Request senior help + anaesthetist
Instigate full observations, commence IV fluids, broad spectrum antibiotics
Catheter & fluid balance chart
Request investigations

Give “tools” - phone a friend, ask for MCQ options etc
Severe hypertension

Aims

- To demonstrate multidisciplinary team-working in the care of an unwell woman
- To commence basic life support and airway management in an obstetric patient
- To demonstrate good communication skills

i) hospital setting (video)

Scenario: primip at 32 weeks admitted with headache and raised BP. History of abnormal movements at home immediately prior to admission. Fits on admission

Participants: MW1, MW2, co-ordinator, HCA, obstetricians x2, anaesthetist x1, ODP, role player

Video feedback highlighting good (and bad) examples of communication and good team working). Ask all participants what they felt their role to be in scenario

ii) Community setting (no video)

Scenario: first pregnancy, SVD. Asked to visit on 2nd postnatal day as BP raised during labour, no treatment. On arrival, woman restless and agitated. Fits while taking BP

Participants: role players for patient and mother/sister, CMW (and GP if FY2/ GPST on day)

Use active observer sheets as small number of participants (appendix 1)
Obstetric Haemorrhage

Aims
- To demonstrate knowledge of local arrangements for obtaining blood products
- To demonstrate competency in fluid resuscitation
- To show understanding of the causes and treatment of postpartum haemorrhage

i) Antepartum haemorrhage
Scenario: 34 year old P4 currently 36 weeks gestation. Reports fresh PV bleeding, more than a period. On admission, pale and clammy, blood soaked through clothing

Participants: MW1, MW2, co-ordinator, HCA, obstetricians x2, anaesthetist x1, ODP.

Video feedback highlighting good (and bad) examples of communication and good team working). Ask all participants what they felt their role to be in scenario.
Discuss possible causes of APH and different approaches to management inc assessment of fetal well being

ii) Postpartum haemorrhage
Scenario: 32 year old woman had SVD 20 mins ago. Baby 4.1kg, needed McRoberts to deliver shoulders. feels unwell and complains of feeling “wet”

Participants: MW1, MW2, co-ordinator, HCA, obstetricians x2, anaesthetist x1, ODP.

Video feedback highlighting good (and bad) examples of communication and good team working). Ask all participants what they felt their role to be in scenario.
Discuss how to obtain blood in an emergency including use of communication tools and flowcharts
Discuss possible causes of PPH and management of atonic PPH